Psychosocial Care for Adult and Child Survivors of the 2004 Tsunami Disaster in India

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The tsunami disaster in South Asia affected the mental health of thousands of survivors, but psychological aspects of rehabilitation are frequently overlooked in public health initiatives. From January to March 2005, teams from the National Institute of Mental Health and Neurosciences in Bangalore, India, traveled to south India and implemented a "train the trainer" community-based mental health program of psychosocial care to facilitate the recovery of child and adult survivors. Psychosocial care has applications to natural and man-made disasters in developing countries. (*Am J Public Health.* 2006;96:1397–1398. doi:10.2105/AJPH.2005.064428)

The tsunami disaster in South Asia affected the emotional health of thousands of child and adult survivors, but mental health aspects of relief and rehabilitation frequently have been neglected in disaster initiatives.[1,2]

The National Institute of Mental Health and Neurosciences, located in Bangalore, India, has been at the forefront of providing mental health care in disasters and has developed and implemented a model of psychosocial care that provides a broad range of community-based interventions to promote psychological rehabilitation of survivors and community cohesion. Teams of psychiatrists, psychologists, and psychiatric social workers from the National Institute of Mental Health and Neurosciences traveled to the most devastated areas in the states of Tamil Nadu and Kerala and the Andaman Islands in January 2005 to provide training in mental health interventions for child and adult survivors. We describe the experience of professional teams who traveled to the cities of Nagappattinam and Cuddalore in Tamil Nadu, where most of the Indian fatalities occurred.

METHODS

A "train the trainer" model was used; a 3-day experiential training program in psychosocial care was provided for nongovernmental organization workers, teachers, and local health care providers who subsequently trained 1050 community-level workers at the disaster areas to offer basic mental health care to adult and child disaster survivors. The training format, along with structured therapeutic activities and instructive manuals, had been developed by the National Institute of Mental Health and Neurosciences teams in the aftermath of the Gujarat earthquake in 2001 and the Gujarat riots in 2002.[3] Trainees were taught to recognize normal reactions to the tsunami disaster, including initial shock, disbelief, panic, and hypervigilance to the possibility of a second tsunami wave. Trainees also were taught to identify individuals with severe reactions, such as despair, guilt, recurrent flashbacks, and feelings of loss which required referral to professionals.

In the training program, the following essentials of psychosocial care for adults were taught:

- Feelings must be normalized and ventilated to help survivors understand the disaster and the changes they experienced in body and mind.
- Somatic and psychological symptoms could be decreased by listening, encouraging relaxation, promoting externalization of interests, and engaging in recreational activities in a group setting.
- Culturally appropriate proverbs, metaphors incorporated into storytelling, and cultural rituals may be used to facilitate a reinterpretation of the meaning of the disaster with attention to restoration of coping mechanisms.
- Community cohesion would be strengthened by facilitating group activities and support groups.

RESULTS

As described in the previous section, emotional support was incorporated into relief and rehabilitation efforts. Group sessions were held in the affected communities on a daily (and later a twice-weekly) basis, often in temporary housing camps where disaster survivors resided. Local community workers trained in psychosocial care were able to relate to survivors in terms of their language and cultural traditions and maintain continuity of care. This cascading model was used in the tsunami area to train 1050 volunteers in the field during the first 3 months after the disaster.

Many child victims and survivors experienced the violence of the tsunami disaster; lost parents, siblings, and friends; and required mental health intervention. The initial response was to reunite children with their families, but many children lost their parents and were placed into temporary refugee camps. To restore normalcy to their lives, routines of daily living were put into place, and structured routines were initiated to promote a sense of security and predictability for the children. Playgroups were established by trained community workers within the camp settings, which minimized the stigmatization that is inherent in individualized psychotherapy in this culture. For more severe cases, the option of referral to a psychiatric facility was available.

In areas that were less affected, primary schools were reopened, and teachers trained by the National Institute of Mental Health and Neurosciences teams administered psychological support in the form of play therapy to their students. By conducting group sessions with children in a natural school setting, officials attempted to normalize the children's experience and provide needed group support to traumatized children who verbalized anxieties about loss of their school, their teacher,

their school records, and their future educational opportunities.

DISCUSSION

Developing countries with large, impoverished populations experience the most severe consequences of disasters. The "train the trainer" model of psychosocial care has implications for natural and man-made disasters in resource-poor settings where mental health professionals are in short supply. Studies that test the effectiveness of psychosocial care in emergencies are needed but are limited by the ethical dilemma of withholding interventions to control groups and the logistics of performing research in disaster situations. ■

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Human Participant Protection

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